**IMMUNIZATION VERIFICATION OF INTERNATIONAL TRAINEE**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date of birth | / / |
| Nationality |  | Sex |  |
| Phone |  | E-mail |  |

**Mandatory Immunizations**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. Hepatitis B** | | | | | | | | | | |
| 1) Vaccination History  (three doses) | Date: / / | | | Date: / / | | | | | Date: / / | |
| 2) Immunization status | Date: / /   * Immune * Non-Immune | | | | | * hepatitis B carrier | | | | |
| **2. Varicella** | | | | | | | | | | |
| 1) Vaccination History  (Two doses) | | Date: / / | | | | Date: / / | | | | |
| 2) Immunization status | | Date: / /   * Immune * Non-Immune | | | | History of disease | | | | |
| Date: / / | | | | |
| **3. MMR** | | | | | | | | | | |
| 1) Vaccination History  [Two doses) | | Date: / / | | | | | | Date: / / | | |
| 2) Immunization status | | Measles | | | Mumps | | | | | Rubella |
| Date: / /   * Immune * Non-Immune | | | Date: / /   * Immune * Non-Immune | | | | | Date: / /   * Immune * Non-Immune |
| **4. Tuberculosis Screening** | | | | | | | | | | |
| Chest X-ray  \*The result of a chest X-ray taken within 1month is required. Chest X0ray must have copy of report attached | | | | | | | | | | |
| Date: / / | | | Result | | | | Positive  Negative | | | |

Hepatitis B, Varicella, MMR: Please fill out **either** vaccination history **or** immunization status.

These immunization information must be verified by a physician.

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| **I hereby certify that the above information is true and correct.**  An official stamp from a doctor’s office, clinic or health department and an authorized signature must appear here or this form will not be approved  Date  Physical or Authorized Signature  Official Office Stamp Here |